

TOPIC 2

FINANCIAL SUSTAINABILITY

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Raising revenues through cost recovery, with the primary goal of improving financial sustainability of health care systems, has been the focal point of financing reform in Africa. Severe budget constraints have forced ministries of health (MOHs) to find needed funds outside their normal budgets, funded with central government tax revenues. The likelihood that external donor assistance will dry up, leaving a sizable funding gap also motivates financing reform. Funding in many countries already falls short of amounts needed for adequate health care, even with their government budgets and donor assistance. Health ministries in those countries cannot maintain improvements in the health status, much less expand those improvements.

Financial Sustainability Goals

Ministries' primary goals for cost recovery in relation to financial sustainability have thus been to:

- > help fill the gap between government resources and funds needed to maintain or improve health services
- > establish a cost-sharing principle whereby the national government continues to pay health worker salaries and fixed infrastructure costs and users of the health care system pay for at least part of the medicines and services they receive directly
- > assure the long-run financial sustainability of health services by becoming more independent from external donor assistance.

Financial and Other Aspects of Sustainability

Financial sustainability in African health systems means having enough reliable funding to maintain current health services for a growing population and to cover the costs of raising quality and expanding availability to acceptable levels. Usually the financial sustainability goal also means achieving these funding levels with a country's own resources.

So far, ministries have concentrated their financing reform efforts on raising revenues through user fees, but:

- > There are many other ways of mobilizing new resources such as: insurance, broadly based social financing, changes in government budget priorities to increase health care allocations, improvements in the central government's tax capacity.

- > Institutional, political, organizational, behavioral, medical, and clinical reforms are equally important for sustainability.

Both points must be kept in mind when discussing sustainability, although a detailed discussion of the second point would exceed the scope of this presentation.

Policy Issues for Cost Recovery and Financial Sustainability

Raising revenue through user fees is not entirely new for government health systems in Africa. For quite some time, many countries have officially had fees for inpatient hospital services. And church missions and other private, non-profit health care providers have a long tradition of charging fees, even in the poorest rural areas. Traditional healers and birth attendants have required payment in cash or in kind, and market vendors have sold traditional and western medications to urban and rural African populations.

Many of

QUESTION 4: Are people willing to pay for health services?

IN BRIEF: Yes. Willingness to pay should no longer be an issue for health care financing reform in sub-Saharan Africa. A large majority of the population, at every income level, expresses a willingness to pay for health care, especially the modest fees ministries usually propose for health services and medicines. Other factors than willingness to pay fees can as strongly influence an individual's decision to use health care.

What evidence is there that people will pay for health care?

Evidence abounds that consumers in sub-Saharan African countries already spend large sums for health care services and medicines, even in the absence of official government cost recovery policies.[10,22,39,51] People also say they would pay more to improve care at public health facilities.

- > In the Central African Republic, household surveys revealed that people at every income level would pay more

Is willingness to pay fees the only influence on a person's choice of health care?

No. Fear that unwillingness, or inability, to pay fees will curtail use of health care is a main reason for policy concern about user fees, but other factors are equally important in a person's decision to seek health services or to use a particular provider.

Use of health services is also influenced by perceived quality of care, type of service (preventive or curative), and type of provider (traditional practitioner, church mission clinic, government health post). The costs of waiting and travel time as well as travel costs figure in a person's choice of health care services. These other costs can easily exceed modest user fees and can play a stronger role in the decision to seek care. Cultural factors, too, are often more important than fees. And both distance from a health facility and perceived quality are often more important determinants than fees, especially for the poor. [2,6,10,15,17,18,54] (*See Questions 12 and 13*)

QUESTION 5: Can people afford to pay for health services?

IN BRIEF: African households spend substantial amounts of money for health services and medicines, regardless of government fee-sharing policies. Many different factors affect the "affordability" of these expenditures. Some households find them harder to pay than do others, and a few may not be able to pay even a modest cost recovery fee. Health ministries need to build into their cost recovery policies mechanisms for evaluating and accommodating variations in ability to pay and in factors affecting the affordability of health care in relation to other household needs.

What criteria govern "ability to pay?"

A \$10 expenditure on medicines is a bigger piece of a poor household's income than a better-off household's, but there is no consensus on criteria for "ability to pay" for health care. In the absence of standard criteria, many MOHs take what people now pay for health care as a first indicator of what they can pay.

Most households in Africa spend between 2 percent and 5 percent of their income out-of-pocket for health services and medicines. The poorest households often spend 5 percent or more—even in the absence of user fees for public health care. [19,30,47,51]

People often have to borrow to make these expenditures. Evidence from Tanzania in the early 1990s, when government health services were officially free, shows that 60 percent of respondents in a large household survey said that they had to borrow (36 percent) or make special sales (14 percent) to pay for health care in the previous year, while others (10 percent) of *all* income quintiles said they were completely unable to pay for health care. The rural population, who were on average poorer and fa

income). In Nigeria, the poorest households spend 8 percent of income on malaria treatment compared with 3 percent for middle income families. [12,20]

- > In the Central African Republic before the official introduction of fees for services and medicines at government health facilities, the poorest rural families said they were spending an average of F CFA 1,200 (0.6 percent of income, equivalent to US\$4.00) for one outpatient illness episode. Middle-income urban households reported average spending of F CFA 4,100 (also 0.6 percent of household income, equivalent in this instance to \$13.76). Upper income families in Bangui, the capital, were spending F CFA 9,000 (0.3 percent of household income, equivalent to \$30) for an average outpatient illness episode.[10]

What are some of the factors that affect ability to pay?

What people can afford to pay for health care depends on many different factors. They include:

- > Total family income and family size
- > The specific fee for each type of health service
- > How many family members get sick in a year
- > How much they must also pay for education, water, and other services
- > Their spending for other basic needs in relation to total household income.

Ability to pay may also vary by season, especially for rural agricultural populations, and with national economic changes such as currency devaluations. Ability- to-pay assessments have to take into account not only the price of one medication or service but also the cost of a series of services and medications a household will likely need in a year.

What type of research is needed to assure that fees are affordable and sustainable under cost recovery reforms?

Net savings over spending for health care prior to reforms may be one of cost recovery's main benefits to households, making health care clearly more affordable. [10,21,53] (*See Questions 12, 13, and 17*) Nevertheless, little research has been done to determine what range of spending or proportions of income is "affordable," and hence sustainable by the population. Some empirical

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measure would help to protect equity needs and assure that patients can pay the fees charged. Research should be done to:

- > define criteria for determining "ability to pay"
- > develop monitoring indicators
- > incorporate means of accommodating variations in ability to pay into the design of cost recovery initiatives tailored to local conditions (e.g., seasonal payment mechanisms where needed; effective indicators of income for means testing; administratively feasible sliding fee scales).

QUESTION 6: **Can cost recovery initiatives raise enough revenue to make a difference for financial sustainability in countries where most people are poor?**

IN BRIEF: Theoretically, yes. User fees can contribute modestly to total government recurrent costs for health care and more toward recovery of non-salary recurrent costs. A variety of implementation factors have kept cost recovery rates below their potential. These factors have often been a bigger obstacle than people's willingness or ability to pay. If cost recovery is to help with financial sustainability, legal and management safeguards need to be in place to assure that revenues are used to sustain the service improvements.

How much do user fees contribute to paying government's total recurrent costs of health care?

Little is known about how much cost recovery based on user fees contributes to funding total government costs for health care. The few estimates that have been made are based on data collected in the 1980s before the most vigorous cost recovery initiatives had been implemented. Table 2-1 summarizes data most often cited regarding the contribution of fee revenues to total government spending for recurrent costs (e.g., salaries, medicines, supplies, transport, utilities, and other annual operating costs) of health services. As the data indicate, cost recovery rates are usually under 10 percent when calculated as percentage of total MOH recurrent costs.

TABLE 2-1 Cost recovery in sub-Saharan African countries, 1980s <i>(percentage of total government health care spending)</i>	
<i>Costs recovered</i>	<i>Countries</i>
1–5 percent	Botswana, Burkina Faso, Burundi, Côte d'Ivoire, Kenya, Malawi, Mali, Senegal, Swaziland, Zimbabwe
6–8 percent	Lesotho, Mozambique, Rwanda
12 percent	Ethiopia, Ghana, Mauritania
<i>Source:</i> Compiled from Vogel 1988 and 1989. [44,45]	

At facility level, how much of recurrent costs are recovered?

Few health financing reforms involving user fees in sub-Saharan Africa attempt to recover salary costs, which often amount to between 60 percent and 80 percent of total recurrent costs. Instead, they are designed to contribute to the much smaller proportion of recurrent costs absorbed by medicines, supplies, transport, and other non-salary operating costs. Estimates using this measure are most often made at the facility level.

By this measure, user fees generate between 30 percent and 40 percent (occasionally over 50 percent) of non-salary recurrent costs at outpatient health facilities in sub-Saharan African countries. When costs of medicines alone are used as the indicator, cost recovery can be as high as 100 percent. Fee revenues from cost recovery initiatives sometimes equal or exceed the amounts governments previously allocated to health care facilities for non-salary recurrent costs, especially for drugs. [10,19,33,49,52] (*See Questions 7 and 11*)

Do cost recovery rates increase over time?

Often. For example, cost recovery in Ethiopia rose from 12 percent of total government health care spending in the early 1980s to 20 percent by the mid-1980s. Cost recovery rates also improved in Ghana (from 5 percent in 1984 to 12 percent in 1987), Lesotho (from 6 percent in 1984 to 9 percent in 1991), Côte d'Ivoire (from 3 percent in 1986 to 7 percent in 1993), and Zimbabwe (from 2 percent in 1986 to 4 percent in 1991). Recovery rates in other regions also rise over time. In China, for example, cost recovery as a percentage of all health care spending rose from 78 percent in 1985 to 85 percent in 1987. [31,39,45,51]

Increases and decreases over time can occur for many reasons and have to be assessed in the specific situation. Among the main reasons for increased cost recovery rates are: stronger cost recovery policies, improved experience and enforcement of fee collection, a rise in fees to account for inflation, or a drop in government funding, which effectively raises the cost recovery rate even though fee collection performance does not improve. Rates have also declined in countries such as Ethiopia during war or political turmoil. Hospital rates have declined where fees are not updated to keep pace with inflation (e.g., Turkey, Botswana, Jamaica, Lesotho, Zimbabwe). [3]

As cost recovery rates improve, do revenues further financial sustainability of the system?

It all depends. There is little documented long-term evidence that fee revenues are used to enhance financial sustainability of the health care system or services in specific public health facilities. Some drug revolving funds have managed to channel fee revenues back into operations, but many other small-scale efforts have failed. More time is needed for a longer term evaluation of

cost recovery efforts, and national level assessments will be necessary after smaller initiatives and phased programs have had time to expand and become institutionalized throughout the country.

The cost recovery potential of user fees depends on such factors as fee levels charged, corresponding utilization changes, health worker incentives for collection, fee exemption policies and practices, implementation system procedures, and how well good practices are institutionalized. [14,16,22,23,26,27,35,39,45,51] Evidence about people's willingness to pay for health care services suggests that higher than token prices could be charged, bringing in more revenue without causing hardship for most people.[22] Financing mechanisms such as prepayment or insurance may raise more revenues than straight fee-for-service systems. [10] (*See Questions 8 and 22*)

User fees' contribution to financial sustainability of health services, especially to quality improvements, depends on whether or not fee revenues are channeled back into the health care system, and into the specific health facilities raising the revenues, to pay for the costs associated with improved service delivery. Although fee levels and fee collection/exemption practices do affect how much revenue is raised, implementation details and legal and management safeguards are key to assuring that the revenue is used to sustain the system. [52]

QUESTION 7: What is the impact of cost recovery on financial sustainability at primary care facilities and hospitals?

IN BRIEF: Total cost recovery rates for individual public health facilities in Africa are generally modest. Measured against goals of covering non-salary recurrent costs, especially costs of drug supplies, cost recovery rates are higher. Even when cost recovery rates are low, user fees often fill important funding gaps that have prevented quality improvements at government health facilities.

How much has cost recovery contributed to funding at primary and secondary facilities?

Cost recovery at health centers, health posts, and dispensaries has been modest but has filled important gaps. (*See Table 2-2*) In many sub-Saharan African countries, the major share of MOH budgets goes to hospitals, leaving primary and secondary providers relatively underfunded.

Many financing reform initiatives have focused on recovering the non-salary portion of recurrent costs of outpatient services and medicines at these primary and secondary care facilities.

- > In Benin, user fees under the Bamako Initiative in the early 1990s produced 43 percent of total facility recurrent costs, including salaries, and 100 percent or more of all medicine costs. Cost recovery revenues in Guinea's Bamako Initiative covered on average 47 percent of non-salary recurrent costs, while 52 of 95 health centers covered at least 100 percent of their non-salary operating costs in 1990.[33,43]
- > In Senegal, Bamako Initiative sites in 7 districts recovered, on average, over 100 percent of drug and related administrative costs.[7,53]
- > In Niger, revenues from user fees in 1993 produced revenues equal to 52 percent of drug costs and 35 percent of the costs of both the medicines and pharmacy administration in one district. In another district, which instituted a health tax in addition to user fees, revenues covered 149 percent of drug costs and 89 percent of drugs plus administration.[10]

Even when fee revenues are just a fraction of total spending on government-provided services, they can help individual facilities to alleviate shortages of basic medicines and other critical supplies (e.g., bandages, alcohol, gloves, and anesthetics). In many countries or regions where facilities receive limited supplies of drugs, or none, from the health ministry, drug revolving funds financed by user fees have been solely responsible for drug availability. User fee revenues are often

the only source of funds for any operating cost other than salaries and drugs (e.g., fuel for refrigerators and vehicles, office supplies, routine maintenance).

TABLE 2-2 Recovery of non-salary recurrent costs by user fees at ambulatory health facilities in Africa	
<i>Percentage covered</i>	

How much of their costs do hospitals recover with fees?

Several analysts have made extensive efforts to compile data on hospital cost recovery rates, but sources are difficult to locate, and data are not systematically collected. Nor do they always reflect comparable methods of estimating cost recovery rates. Table 2-3 nevertheless suggests the range of experience with hospital cost recovery.

Few public hospitals in Africa or elsewhere raise much of their operating costs from user fees. A variety of managerial weaknesses are to blame for keeping hospital fee revenue below potential, including failure to update fees and to claim insurance reimbursements and lack of incentives for fee collectors.[3]

TABLE 2-3 Recurrent costs covered by user fees in public hospitals, 1980s	
<i>Percentage of total recurrent costs recovered</i>	<i>Selected public hospitals, various countries</i>
10 percent or less	<ul style="list-style-type: none"> > Sub-Saharan Africa: Botswana, Central African Republic, Lesotho, Swaziland, Senegal, Zambia > Other regions: Jamaica, Honduras
15-25 percent	<ul style="list-style-type: none"> > Sub-Saharan Africa: Ethiopia, Ghana, Niger, Zaire > Other regions: G Turkey, Indonesia
38 percent	G Bolivia
80-100 percent	<ul style="list-style-type: none"> > Sub-Saharan Africa: Nigeria >

QUESTION 8: What else could be done to tap potential sources of finance for public health facilities?

IN BRIEF: Insurance reimbursement for public health facilities could be expanded and "best practices" could be adopted from nongovernmental organizations (NGOs) that have been successful with cost recovery through user fees. Weaknesses in implementation, large numbers of fee exemptions, and failure to collect unpaid bills and reimbursement from insurance and government health plans and social assistance programs have kept cost recovery rates low, especially in public hospitals. If cost recovery or insurance reimbursements are to help with financial sustainability, revenues cannot be used in the short run to replace, or reduce, government funding for health services.

What potential does insurance reimbursement have for government health facilities in Africa?

Financing through health insurance, especially for public hospitals, is least developed in sub-Saharan Africa, although it is not widespread in any developing country region. Generally, it is the countries with a large population employed in the formal sector—such as Argentina, Brazil, Jordan, Korea, Turkey, and Uruguay—that tend to have significant public or quasi-public health insurance programs that cover hospital services. In general, reviews of hospital financing experience conclude that hospitals in most countries have not generated more than a small fraction of their revenues from non-government financing sources. The general reasons for this pattern tend to be due to various administrative failures and scope of formal employment, but not to level of per capita income or prevailing government ideology.[3]

In most African countries, government health plans for civil servants and their families are the predominant source of health insurance. National or local government social assistance programs also often exist to pay for health services for the indigent. In many cases, however, these plans have not worked well to reimburse health facilities for providing services to the eligible people.

- > In the Central African Republic, government has been in arrears in its reimbursements to central hospitals for treating civil servants and their families, which often make up 40 percent of their patient load. Reimbursements (80 percent of charges for the patient's care) are to resume in 1995. Under the government's renewed commitment to health financing reform, the President of the Republic signed a decree establishing a line item in the national budget for reimbursing services under the government's health plan for civil servants.[19,48]
- > In Mali, a single ministry's reimbursements for services to its employees and their dependents raised one hospital's revenues 7 percent in one year.[51]
- > In Ghana, exemptions for MOH employees and their families cost government health facilities 21 percent of their potential fee revenue.[46]

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Where privately funded health insurance exists, hospitals can be the major beneficiaries of the additional source of funding. In other instances, private insurance represents an untapped source for public hospitals.

- > Less than 5 percent of private health insurance claims in Jamaica and in Zimbabwe went to public hospitals. In contrast, hospital financing through prepaid capitation plans covers about 43 percent of the population in Uruguay.[3]
- > A community-based health insurance plan in Bwamanda, Zaire, covers 80 percent of the district hospital's costs from user fees and insurance reimbursement, while 90 percent of the insurance plan's income goes to pay hospital charges. Hospital cost recovery rates increased from 48 percent of operating costs in 1985 to 79 percent in 1988.[7]
- > In Kenya, after reforms to improve fee structures, fee collection, insurance claiming procedures, reimbursement rates, and management systems at government health facilities, total monthly revenue tripled at provincial, district and sub-district hospitals. When these reforms reach their full potential, income from fees and insurance is expected to provide revenues equal to 39 percent of the government allocation to hospitals, after deducting the revenue share that the government re-allocates to health centers and dispensaries for preventive and primary health care.[9]
- > In China, all health institutions were instructed in 1981 to cover all non-salary recurrent costs through user fees. In addition, about 20 percent of the population is covered by health insurance plans that cover 100 percent of hospital charges and another 15 percent of the population has more limited hospital coverage. These reforms have helped health facilities generate revenues that cover large shares of recurrent costs (85 percent on average). However, they have led to rapid inflation in health care costs, growing at average annual rate of 17 percent in real terms between 1980 and 1988, primarily due to patients paying user fees and to insurance reimbursements.[3]

What does NGO experience have to offer?

Health facilities operated by church missions and other non-governmental organizations often cover a large part of operating costs through user fees, while serving the poorest population groups. Countries that have substantial experience with NGO health facilities might adapt their cost recovery lessons for public providers.

- > In Senegal, user fees charged by church mission health posts represented 95 percent of all their revenues.[5]
- > In Tanzania, between 50 percent and 80 percent of mission health posts' total recurrent costs including salaries came from user fees. In Uganda and Zaire, NGO hospitals have recovered between 75 percent and 95 percent of annual operating costs through user fees.[7,28,51]

- > Church mission hospitals recovered 13 percent of costs in Swaziland, 46 percent in the Central African Republic, 56 percent in Tanzania, and 72 percent in Uganda in the late 1980s and early 1990s.[39]

NGO project experience among relatively poor populations in countries in other regions (e.g., Bolivia, Peru and Haiti) show similar patterns to those found in sub-Saharan African countries.[13,24,38] In Haiti, health facilities run by one non-governmental organization raised 92 percent of non-salary recurrent costs for outpatient services, and in Bolivia, a non-governmental organization, PROSALUD, covered 80 percent of outpatient costs from user fees in one site and 59 percent in another.[38,41]

Do any of these options lessen the need for government funding?

Probably not in the short run. Revenues from fees neither cover—nor are expected to cover—salaries, which make up the bulk of recurrent costs for government health services, nor do they always cover non-salary recurrent costs. Even with improved performance, cost recovery revenues are not likely to reach levels that could offset government spending in the near future. Insurance mechanisms, while promising, take time to establish, are administratively complex, and require careful planning and monitoring to safeguard efficiency, cost containment, and equity.(*See Question 22*)

People might be willing and able to pay more. Fees affordable for most people, but higher than token fees, could more than cover the cost of collecting fees and bolster financial sustainability and quality improvements, according to the general consensus among MOH personnel in Africa.[22]

Households, in fact, already contributed more than government to overall health care financing in sub-Saharan Africa in 1985–90, especially in the lowest income countries. Private spending was 52 percent of total health

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1. Abel-Smith, B., and P. Rawal. 1992. "Can the poor afford 'free' health services? A case study of Tanzania."
Health Policy and Planning

15. Gertler, P., and J. van der Gaag. 1990. *The Willingness to Pay for Medical Care: Evidence from Two Developing Countries*. Baltimore: Johns Hopkins University Press.
16. Knippenberg, R., D. Levy-Bruhl, R. Osseni, K. Drame, A. Soucat, and C. Debeugny. 1990. "The Bamako Initiative: Some Experiences." *Children in the Tropics*. International Children's Centre, Paris.
17. Lavy, V. and J. Germain. Forthcoming 1995. "Tradeoffs in Cost Quality and Accessibility in the Utilization of Health Facilities: Insights from Ghana." In R. Paul Shaw and Martha Ainsworth, eds., *Financing Health Services through User Fees and Insurance: Country Case Studies from Sub-Saharan Africa*. Population and Human Resources Department, The World Bank, Washington, DC.
18. Lavy, V., and J.M. Quigley. 1993. "The Willingness to Pay for the Quality and Intensity of Medical Care." LSMS Working Paper 94. The World Bank, Washington, DC.
19. Leighton, C. 1994. "A Proposed Fee Structure and Prices for A National Program of Cost Recovery for Health Services in the Central African Republic." Technical Note No. 39. HFS Project, Abt Associates Inc., Bethesda, MD.
20. Leighton, C., with R. Foster, J. Ouma, J. Wang'ombe, O. Ekanem, W. Brieger, M. Ettling, S. Zaman. 1993. "Economic Impacts of Malaria in Kenya and Nigeria." Major Applied Research Paper No.6 (Phase I-III). HFS Project, Abt Associates Inc., Bethesda, MD.
21. Litvack, J. and C. Bodart. 1993. "User Fees Plus Quality Equals Improved Access to Health Care: Results of A Field Experiment in Cameroon." *Social Science and Medicine* 37(3).
22. Makinen, M., and C. Leighton. 1993. "Workshop on Health Financing and Sustainability in Africa: CCCD Regional Conference on Progress in Child Survival, Dakar, Senegal." Policy Paper No.8. HFS Project, Abt Associates Inc., Bethesda, MD.
23. Makinen, M., and K. McInnes. 1991. "Evidence on the Effectiveness of User Charges: Experiences from Africa." Abt Associates Inc., Bethesda, MD.
24. Makinen, M. 1991. "Economic Analysis of the Strengthening Health Institutions Project, Peru." Technical Note No.6. HFS Project, Abt Associates Inc., Bethesda, MD.
25. Mbiti, D.M., F.A. Mworio, and I.M. Hussein. 1993. "Cost Recovery in Kenya." Letter to *The Lancet*. 341(February 6): 376-7.
26. McInnes, K. 1993. "Local Retention of User Fees in Government Health Facilities." Small Applied Research Paper, No. 3. HFS Project, Abt Associates Inc., Bethesda, MD.
27. McPake, B. 1993. "Community Financing of Health Care in Africa: An Evaluation of the Bamako Initiative." *Social Science and Medicine* 36(11).
28. Mujinja, P.G.M., and R. Mabala. 1992. "Charging for Services in Non-Governmental Health Facilities in Tanzania." Technical Report Series No. 7. Bamako Initiative Unit, UNICEF, New York.

HEALTH CARE FINANCING IN AFRICA

29. Mwabu, G., M. Ainsworth, and A. Nyamete. Forthcoming 1995. "Effects of Prices, Service Quality, and Availability on the Demand for Medical Care: Insights from Kenya." In R. Paul Shaw and Martha Ainsworth, eds., *Financing Health Services Through User Fees and Insurance: Lessons from Sub-Saharan Africa*. Population and Human Resources, The World Bank, Washington, DC.
30. Mwabu, G., and W. Mwangi. 1986. "Health Care Financing in Kenya: A Simulation of Welfare Effects of User Fees." *Social Science and Medicine* 22 (7).
31. Nolan, B., and V. Turbat. 1993. "Cost Recovery in Public Health Services in Sub-Saharan Africa." Economic Development Institute, The World Bank, Washington, DC.
32. N'Diaye, B. 1989. Transcript of speech given by the President of the Association for the Promotion of Health in Pikine, Senegal at the Ministry of Health/REACH Project Cost Recovery Workshop, Bangui, C.A.R.
33. Parker, D., and R. Knippenburg. 1991. "Community Cost-Sharing and Participation: A Review of the Issues." Technical Report Series No. 9. Bamako Initiative Unit, UNICEF, New York.
34. Reveillon, M. 1987. "Aspects Economiques et Financières de la Participation des Populations au Développement des Services de Santé de Base à Pikine (Senegal)." *Medicus Mundi*, Belgium.
35. Russell, S., and L. Gilson. Forthcoming 1995. "Cost Recovery in Government Health Services -Is Equity Being Considered?" London School of Hygiene and Tropical Medicine Departmental Publication Series.
36. Sauerborn, R., C. Bodart, and R. Owona. 1993. "Provincial Revolving Drug Funds for the Recovery of Recurrent Health Service Costs in Cameroon." Harvard Institute for International Development Discussion Paper No. 468, Cambridge, MA.
37. Sékou, H., M. Saidou, and I. Wassiry. 1991. "Etude du Tri a l'Hôpital National de Niamey." USAID Niger Health Sector Support Grant.
38. Setzer, J., and G. Cross. 1992. "A Study of User Fees at CDS Facilities in Haiti." Abt Associates, Inc., Bethesda, MD.
39. Shaw, R. Paul and C. Griffin. 1995. *Financing Health Care in Sub-Saharan Africa Through User Fees and Insurance*. Directions in Development, The World Bank. Washington, DC.
40. Shepard, D., T. Vian, E. Kleinau. 1990. "Health Insurance in Zaire." Working Paper, Africa Technical Department, The World Bank, Washington, DC.
41. Straughan, B. 1992. "Self-Financing Health Project Brings Quality Care to Bolivia's Poor." *Front Lines*. USAID, Washington, DC. (February).
42. Unger, J.P., A. Mbaye, and M. Diao. 1990. "From Bamako to Kolda: A Case Study of Medicines and the Financing of District Health Services." *Health Policy and Planning* 5(4): 367-377.

43. UNICEF. 1992. "The Bamako Initiative: Progress Report to the UNICEF Board 1992 Session." New York.
44. Vogel, R. 1989. "Trends in Health Expenditures and Revenue Sources in Sub-Saharan Africa." Unpublished report. Population and Human Resources Department, The World Bank, Washington, DC.
45. Vogel, R. 1988. "Cost Recovery in the Health Sector: Selected Country Studies in West Africa." Technical